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ABSTRACT

This paper presents recent information on the use of mass communication to combat the acquired immunodeficiency syndrome (AIDS) epidemic in Latin America. The paper takes up the following topics: (1) communication as anti-AIDS weapon; (2) the information effort lag; (3) targeting AIDS information; (4) delivering the message to health professionals; (5) anti-AIDS campaigns for Latin American publics (detailing specifics of campaigns in Brazil, Chile, Columbia, Haiti, Mexico, Nicaragua, and Venezuela); and (6) the AIDS problem in Brazil (the largest country in Latin America). One hundred thirty-four endnotes are included. (SR)

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Communication Efforts Against AIDS in Latin America: An Updated Report

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INTRODUCTION

This paper presents recent information on the use of mass communication to combat the Acquired Immunodeficiency Syndrome (AIDS) epidemic in Latin America. While the findings suggest that at the outset there was a lag between the onset and rapid spread of AIDS and health communication efforts--as in the United States--both government and private agencies have mounted ambitious health campaigns in a relatively short time.

One of the major innovations in the efforts against the AIDS epidemic was the distribution via satellite of proceedings of two Latin American conferences on AIDS, in September 1987[1] from Quito and December 1988[2] from Rio de Janeiro. Additionally, a major conference held in Chile during January 1988 in Chile involved transnational sharing of experiences and perspectives.

However, there still is evidence of a need for a better scientific understanding of health behaviors relating to

sexuality in Latin America, as well as theories and practices concerning health communication and health campaign management. That situation is not unique, however, since most countries are not well-equipped with information that is readily available from central locations.

Nevertheless, the communication attack on the AIDS epidemic in Latin America is marked by dedication and ingenuity in the face of limited resources and opposition from some quarters.

In Latin America, the epidemic--referred to as AIDS in Brazil and SIDA (Sindrome de Inmunodeficiencia Adquirada) in the Spanish-speaking nations--is about three to four years behind the United States of America's contagion growth curve. However, AIDS has spread throughout most of the region. By September 1987, more than 9,000 cases had been reported in the countries of the Americas[3] outside of the U.S. and Canada. At that time, only four Latin American countries reported no AIDS cases.[4] By the end of January 1989, 11,399 AIDS cases had been reported the Americas, outside of the U.S. and Canada, and only the British Virgin Islands and Monserat had reported no cases.[5] The United States had reported cumulatively 84,503 AIDS cases and 48,584 deaths[6] by the same time, and Canada had cumulatively reported 2,196 cases.[7] The number of AIDS cases in the Americas totaled 98,560 by the end of January 1989.

TABLE 1: Reported AIDS Cases in the Americas as of Jan. 31, 1989

Anguilla	1	Grenada	16
Antigua	3	Guadelupe	86
Argentina	196	Guatemala	46
Bahamas	236	Guyana	40
Barbados	67	Haiti	1,661
Belize	11	Honduras	186
Bermuda	92	Jamaica	72
Bolivia	16	Martinique	46
Brazil	4,709	Mexico	1,642
British Virgin Isles	0	Monserat	0
Canada	2,196	Nicaragua	2
Cayman Islands	4	Panama	79
Chile	100	Paraguay	8
Colombia	308	Peru	122
Costa Rica	79	St. Kitts	14
Cuba	43	St. Lucia	11
Dominica	6	St. Vincent	14
Dominican Republic	619	Suriname	11
Ecuador	45	Trinidad/Tobago	336
El Salvador	55	Turks/Calicos	5
French Guiana	113	USA	84,965
		Uruguay	35
		Venezuela	263

SOURCES: The report for the USA was provided by the U.S. Centers for Disease Control and is reported as of Jan. 30, 1989. The other figures were provided by the Pan American Health Organization, and were reported as of Jan. 30, 1989.

By October 1987, Brazil had reported 2,000 persons with AIDS[8] and by the end of January 1989 4,704 cases,[9] vying with France for the second largest number of reported cases after the USA. By the end of January 1989, Mexico had 1,642 cases of AIDS,[10] up from 700 cases in September 1987, making it second after Brazil among the Spanish- or Portuguese-speaking countries of Latin America.[11]

Regarding AIDS virus infections, by September 1987, according to Pan American Health Organization (PAHO) Director

Dr. Carlyle Guerra de Maceda, about 12.5 million persons in Latin America were believed to carry the AIDS virus.[12] In the USA, it has been estimated 1.5 to 4 million persons might carry the AIDS virus.[13]

The significance of "reported" cases is that various countries, especially ones in Africa, under-report AIDS cases,[14] either as a result of concern about being stigmatized or due to inadequate epidemiological surveillance resources. By contrast, in the USA it is believed 90 percent of the AIDS cases are reported; in Europe, it is suspected the figures slightly understate the number of cases.[15]

Additionally, there is a considerable lag in the compilation of updated epidemiological statistics concerning AIDS, especially at the international level.

COMMUNICATION AS ANTI-AIDS WEAPON

During an international conference that was concluded in London during the week of Jan. 25, 1988, it was stated that communication is the only means to combat the AIDS epidemic for the foreseeable future.[16] That corresponds with the view of U.S. Surgeon General C. Everett Koop, who said additionally that a vaccine against AIDS is unlikely to be ready before the year 2000.[17] Earliest possible prevention of Human Immunodeficiency Virus (HIV) infection is essential, explained Dr. Claude Betts of Panama's National Children's Hospital: "Each case we prevent

today probably will mean 10 or 100 or 1,000 fewer transmissions 10 years from now."[18] The problem of prevention of HIV infections is considerable, since the number of infected persons who go on to develop what is called full-blown AIDS, the lethal stage, doubles every 11 to 13 months. Approximately 25 to 50 percent of those who are HIV-infected are believed likely to go on to full-blown AIDS.[19] A British economist at St. Stephen's Hospital, London, who developed a statistical model to explain how many infected persons would be needed to account for the current rate of known AIDS cases linked to transfusions suggested that (a) the conversion from HIV-infected status to full-blown AIDS might take as long as 15 years and (b) the projected totals for infection could be considerably higher than presently estimated.[20]

Once full-blown AIDS develops it is almost inevitably fatal. AIDS victims' only hope for survival at present is a drug called AZT (azidothymide). It does not cure AIDS, but only puts it into remission. Supplies of AZT are limited--especially in the Less Developed Nations (LDNs)--and the cost for a year's supply for one person is approximately US$ 7-10,000.[21]

In the USA, hospitalization costs for AIDS victims are estimated to average $150,000 each.

Even though the World Health Organization (WHO) is expected to spend $1.5 billion on AIDS prevention by 1990, in

the LDNs the cost of treatment will exceed by far the cost of prevention programs.[22]

At a minimum, putting a priority on AIDS treatment will divert money from programs relating to other health and social problems. At worst, the spiraling costs could threaten the financial viability of LDN governments.

Moreover, since persons in age groups that are most economically productive or involved in political leadership are ones that tend to be killed by AIDS--particularly individuals in their twenties and thirties--the ramifications are exceptionally serious in terms of pervasive impact.[23]

INFORMATION EFFORT LAG

In general, there has been a considerable time lag between the advent of a substantial increase in the disease and the mounting of mass health education or health information activities. In the USA, for example, the first case of AIDS was identified in 1981--though evidence was discovered later that the disease had killed a young man in St. Louis, Mo., much earlier, in 1969. U.S. Surgeon General Koop, himself, wrote a public health brochure on AIDS and had it published--but that was not until 1986. The Reagan administration blocked the mass mailing of that brochure to households in the nation, although the Congress appropriated $20 million for distribution of the Koop document.[24] Moreover, administration did not move to

initiate a nationwide AIDS campaign through the mass media until early in 1987, with the U.S. Centers for Disease Control advertising for bids. The contract for the project, based on the theme "America Responds to AIDS," finally was awarded to the Ogilvy & Mather advertising agency in August 1987 and the campaign initiated in October 1987.[25] Two other agencies are collaborating to produce messages for the Black and the Hispanic audience segments.[26] To date, however, state and city health agencies, community action organizations, religious groups and the mass media have accounted for virtually all of the AIDS health information activity in the USA. The U.S. government's main activities prior to the initiation of the "America Responds to AIDS" campaign consisted of distribution of the Koop brochure and an AIDS telephone information "hotline." In addition to broadcast and print media ads--all of which depend on mass media contribution of advertising time or space, the campaign is distributing brochures to clinics and other agencies and is holding meetings with public organizations that are dealing with the AIDS epidemic. Widespread mailing of an AIDS brochure has been undertaken.

European governments were much quicker to initiate campaigns. Britain, for example, made a commitment as early as the Spring of 1986 to a national campaign.[27] It also mounted a TV blitz on AIDS early in 1987.[28] Moreover, by mid-1987, various governments or government agencies around the world had

initiated AIDS information programs--ranging from lectures and seminars to hotlines and TV campaigns.[29]

As for mass media reporting about AIDS, there are indications that writers and editors have been slow to recognize the import of the epidemic.

In the USA, the Magazine Index microfilm service shows that relatively few articles on AIDS were published in periodicals during 1984-85. However, a substantial increase occurred in 1986 and the AIDS news flow about AIDS increased markedly in 1987.

At the international level, World Press Review asked foreign news editors who reportedly were "particularly attentive to the Third World" to list the what they thought were the top 10 news stories of 1986.[30] The respondent from Compass News Features, Luxembourg, listed AIDS first and an editor from Gemini News Service, London, listed it third, after South Africa and the Chernobyl nuclear accident. Editors from Associated Press, United Press International, La Nación of San José, Costa Rica, and China Daily of Beijing did not mention AIDS among their top-10 lists.[31]

In Latin America, as the Foreign Broadcast Information Service Index (FBIS) suggests, there may have been a similar lag in reportorial efforts concerning AIDS.

FBIS is a U.S. government agency that monitors content in foreign broadcasts, newspapers, periodicals, wire services and

government statements. Although cross-checking against other Latin American mass media makes it evident this index is not exhaustive, it does suggest a general trend, as indicated in Figure 1: Reportage tends to lag in relation to the rising spread of AIDS, but as the number of cases becomes alarming, mass media attention to the issue begins a moderately increasing distribution curve.

FIGURE 1: FBIS AIDS Content Listings
Under Health/Medicine Category, 7/86-8/87

	Argentina	Brazil	Chile	Colombia	México	Venezuela
July 1986	—	—	—	—	—	—
August 1986	—	—	—	—	—	—
September 1986	—	—	—	—	—	—
October 1986	—	—	—	—	—	—
November 1986	—	1	—	—	—	—
December 1986	—	—	—	—	—	—
January 1987	—	—	—	—	—	—
February 1987	1	1	—	—	—	—
March 1987	—	1	—	—	—	—
April 1987	—	1	1	—	—	—
May 1987	—	—	—	—	—	—
June 1987	—	2	—	—	—	—
July 1987	1	2	—	—	—	—

NOTE: "--" indicates no articles in category during this period.

TARGETING AIDS INFORMATION

If preventive health communication efforts against AIDS are to be successful, the experience to date suggests there are specific audience segments that are critically in need of information:

- Epidemiological specialists--researchers and planners.
- Health care providers--hospital physicians, nurses and lab technicians, and workers in clinics.

- Consumers of medical care--mainly persons who must undergo transfusion with blood or blood products (such as hemophiliacs) or submit to other body-invasive practices such as major or minor surgical procedures or injections.

- Abusers of intravenous drugs.

- Persons who engage in high-risk sexual behaviors: this includes (a) those who are not in monogamous relations with persons who are known to be free of HIV infection and (b) other persons who engage in sex without using barriers (i.e., condoms or dental dams) that prevent the exchange of sexual body fluids such as semen or vaginal fluids during sexual intercourse or oral sex activities.

  This category most commonly applies to (a) homosexuals and bisexuals who engage in oral or anal sex or heterosexual intercourse, (b) heterosexuals who engage in sex with infected persons that exchanges body fluids, particularly with illicit IV drug-users who are especially prone to infection through contaminated hypodermic syringes and (c) prostitutes.

- Street children--especially in the LDNs, this is a group that is susceptible to abuse and exploitation by adults or offers sexual service to gain money to meet survival needs.

- Persons who are <u>not</u> engaged in high-risk personal sexual behaviors--these are individuals whose salutary behaviors, if reinforced, could help inhibit the spread of HIV infection.

  This category covers persons who (a) are not yet sexually active, including children and teen-agers, (b) are celibate or (c) engage in monogamous sexual relations with partners who are not infected, typically within marriage or a long-term relationship.

Segmentation in AIDS campaigns is extremely important, especially where financial resources are limited and optimal planning is essential.[32] Segmentation also enables planners to determine what health beliefs control behaviors in target segments, in order to design appropriate communication

strategies and address appropriate messages to each.[33]

It is problematic whether Latin American planners should look uncritically to the USA for a role model in the AIDS epidemic on those counts. Problems concerning lack of planning coordination, timely response and funding priorities in AIDS prevention efforts have been cited in a U.S. Government Accounting Office study based on interviews with 20 experts across the country.[34] Moreover, news and editorial reports explain that messages that were being prepared for the U.S. Dept. of Health and Human Services did not mention condoms or homosexuality [although a later brochure mentioned that homosexuals were not the only ones affected by AIDS] and were not directed in the main to the segments within the Hispanic or Black populations that were known to engage in high-risk behaviors.[35]

There are additional problems for planners. Failure to utilize segmentation can be dysfunctional, causing low-risk segments of a population to experience high degrees of alarm. Resulting tension can increase the probability of social persecution of suspected or known AIDS virus carriers or even contribute to suicides among persons who misinterpret symptoms and panic due to anticipation of AIDS-inflected ravages of the body and death.[36]

DELIVERING THE MESSAGE TO HEALTH PROFESSIONALS

In 1987, the World Health Organization announced a worldwide program to combat AIDS.[37] The director of that program is Dr. Jonathan Mann, a U.S. citizen.

In September 1987, the Pan American Health Organization, affiliated with WHO, sponsored the first international meeting on AIDS in Latin America.[38] The conference was cosponsored by WHO, the Inter-American Development Bank, the U.S. Centers for Disease Control, the U.S. National Institutes of Allergy and Affective Diseases of the National Institutes of Health, the Latin American Union Against Sexually Transmitted Diseases (ULACETS) and the Abbott, Welcome Group and Electronucleonics laboratories; the U.S. Agency for International Development also offered financial assistance.[39]

More than 500 AIDS experts and public health officials were convened in Quito, Ecuador, for the two-day meeting. Moreover, the conference proceedings were transmitted via satellite--a major public health innovation in Latin America--to an estimated 60,000 other doctors, nurses and medical workers at 500 locations in 30 Latin American countries, including Cuba.[40] In Brazil, the teleconference was rediffused through local public TV channels and some health institutions taped the proceedings for possible use in curricula; the conference also got news coverage in the mass media.[41]

Sixteen hours of programming were broadcast via INTELSAT's Project Share (Satellites for Health and Rural Education).[42]

The conference provided a forum for exchange of information on the epidemiology of AIDS, similarities and differences across nations in regard to factors contributing to contagion, and information designed to correct misperceptions about AIDS.

Reflecting upon the problems raised in the conference concerning the war against AIDS in Latin America, several individuals offered insights to a Washington Post writer who covered the Quito conference:[43]

■ Dr. Ronald St. John, director of the Pan American Health Organization (PAHO) AIDS program: "Precious little is known about sexual behavior in Latin America. I wonder sometimes at us trying to change something we know nothing about."

■ Dr. Thomas Quinn, an AIDS epidemiologist with the U.S. National Institute of Allergy and Infectious Disease and the Johns Hopkins medical institutions: "We still see homosexual men becoming infected with the AIDS virus. They still are not listening. They are not using 'safe sex' [i.e., using condoms or avoiding exchange of body fluids during sex] 100 percent of the time."

■ Dr. Lydia Bond, director of the PAHO AIDS education program: "In Latin America, homosexuals and bisexuals are not as open as in the United States. They do not think of

themselves as homosexual. Consequently, they are not easily found." Moreover, "...if a prostitute is at risk of losing $10 for using a condom [which could prevent her infection or a client's infection with the AIDS virus], she is not going to do it" due to her economic needs and her disbeliefs about susceptibility to death in the vague future.

If those things were not daunting enough, there are major differences in languages in Latin America and the Caribbean. Also, health beliefs tend to vary across nations and even across audience segments within nations.[44] Moreover, it is established by research that different audience segments--even males and females within a particular audience--set different value weights on motivating outcomes or rewards related to implementation of health behaviors.[45]

ANTI-AIDS CAMPAIGNS FOR LATIN AMERICAN PUBLICS

This section focuses on anti-AIDS public education activities in México and in South American nations, but reference also is made to other nations in the Americas.

ARGENTINA: Background about AIDS in Argentina provided by Dra. Laura Astarloa of the Argentine Medical Association:[46]

The first AIDS case in the country was in 1982, but compulsory notification of diagnosed cases of the disease was not required till 1985. Consequently, early data were not accurate. By late 1987, there were 164 cases--all male, with

an average age of 33.9 years. During 1986-87, the number of cases doubled in 11 months, and IV drug use was identified as one of the main sources. As Table 1 shows, the most recent figure is 196. Cocaine, which is used in injection, has been very cheap in Argentina--about $US2 per ounce, contributing to the spread. The spread of drug-related AIDS among youths has been a serious problem: Some 6,000 were believed to have become infected with the virus in one summer in the resort area of Mar del Plata. There are no studies of AIDS carriers at this time. Another area where AIDS seems to be spreading is the borderline between Brazil and Argentina. Spread of the AIDS virus by prostitutes is another problem: since prostitution is illegal, potential carriers may avoid help and detection.

Until mid-1987, the beginning of an offical mass AIDS education campaign remained stalled: Lack of funding was cited as one reason; disagreement about the approach to broadcast messages was cited as another.[47] The newspaper Página noted, however, that advertising time for the AIDS campaign would be free on state-owned radio and TV stations.[48] Now, TV spots are utilized as part of an extensive public education effort.[49] Print media also have been reporting on AIDS and sexual behavior. Moreover, Argentina has created a Health Data Bank to facilitate epidemiological tracking.[50]

Recent information on sexual behaviors in Argentina suggests there are conditions that might facilitate the spread

of the AIDS virus. For example, 64 percent of the respondents in a Centro de Educación, Terapia e Investigación en Sexualidad (CETIS) survey of 307 couples indicated that by age 18, 64 percent of the males and 51 percent of the females had engaged in sexual intercourse.[51] Before settling down with a partner, 35 percent of the males and 18 percent of the females reported they had relations with six or more other individuals.[52] In a population where Sexually Transmitted Diseases (STDs) exist, intercourse with greater numbers of partners increases the probability of infection, especially where use of condoms or other barriers to the exchange of body secretions like semen or vaginal fluids is not practiced. That is significant due to the fact another study by the Centro de Estudios del Estado y la Sociedad (CEDES) found in a study of 121 women that while most reported they used some contraceptive practices, the most commonly cited were nonbarrier methods such as the pill, IUDs or coitus interruptus; among middle-class repondents, only 14 percent said they used condoms or diaphragms.[53] Moreover, the CETIS study revealed another sexual behavior pattern that could facilitate the spread of the AIDS virus: 37 percent of the males and 32 percent of the females interviewed reported they had engaged in anal intercourse.[54] That practice often results in the tearing of skin tissue, thus facilitating the transfer of the virus from semen to blood when the male has AIDS.

BRAZIL: A campaign has been initiated: It began in February 1987 with messages directed in four languages to foreign Carnival visitors.[55] The basic slogan: "Carnival Sem AIDS" (Carnival Without AIDS).[56] The Brazilian effort also includes newspaper and TV spots urging use of "camisinhas de Vênus" (Venus' little shirts), a euphemism for condoms.[57] Following Catholic Church objections to the condom ads--including one that demonstrated a condom being rolled onto a finger--the government cut the media AIDS-education budget from 110 million cruzados (about $US 2 million at the time) to 12 million cruzados (about US$ 600,000).[58] Dr. Pedro Chequer, chief of epidemiology in the Ministry of Health's special AIDS task force, attributed the cut to the lack of resources, other priorities on the government's part and the fact that the Church's objections at the time "mutilated the content of the campaign."[59] Since then, due to the increasing menace of the epidemic, support for the government's campaign has grown in the Catholic Church to the point that Church leaders are urging expanded campaign activity, according to Dra. Lair Guerra de Macedo Rodrigues, coordinator of the Ministry of Health's task force on AIDS.[60] Cardinal Paulo Arns of São Paulo has been one of the Catholic Church officials calling for compassion for AIDS victims and establishment of special hospital facilities to serve them.

On another front, the Minister of the Army, Gen. Leônidas Pires Gonçalves, initiated a brochure that was distributed to soldiers and officials.[61] Moreover, since January 1987, a test for the AIDS virus has been administered routinely on blood donated by soldiers and officials; up until September 1987, 840 of 280,000 donors (0.3 percent) tested positive--about the same percentage of AIDS virus infections as in the Brazilian population, the military indicated.[62]

Despite the funding cutback, WHO's Dr. Mann says Brazil's AIDS education campaign is "one of the best, most aggressive information programs in Latin America."[63]

Various message themes have been directed to specific audience segments and the behaviors that put them at risk of AIDS virus infection. One of the early posters addressed persons engaging in sex with more than one partner: "Mude de idéia--Reduza o número de parceiros--Use camisinha de Vênus" (Change thinking--Reduce your number of partners--Use Venus' "little shirt" [a condom].)[64] In Curitiba, signs at an amusement park frequented by homosexuals advised bisexuals that AIDS could be a danger whether one's partner is male or female.[65] Another poster instructed "Doe sangue é necessário e seguro" (To give blood is necessary and safe).[66] Another poster "AIDS: Assim pega--Assim não pega" (AIDS: Here's how you catch it--Here's how you do not catch it) also provided details on transmission.[67]

CHILE: With 12 million inhabitants, Chile had 60 reported cases by early 1988. As indicated in Table 1, the figure had risen to 100 reported cases in January 1989. However, another 5,000 to 10,000 persons are believed to be HIV carriers, according to Dr. Daniel Villalobos, who is a professor of medicine at the University of Chile, principal advisor in the Ministry of Health's Sexually Transmitted Diseases Control section and also president of ULACETS (Latin American Union Against Sexually Transmitted Diseases).[68]

Chile, like Venezuela which is discussed later, has a centralized health ministry with nationwide representation. Therefore, the nation has been able to use existing infrastructures to collect and disseminate information.

Chile was one of the first countries in Latin America to develop a pilot program in health administration to deal with STDs, as recommended by the World Health Organization.[69]

Operating under the Health Executive Branch of the Ministry of Health are 12 regional offices, which have 27 linked health centers, each with a STD unit. The centers, in turn, operate 310 urban and rural infirmaries. In addition, there are STD units operated by the nation's 182 hospitals.[70]

Since many international sources are involved in contributions to fight AIDS and other diseases, individual countries like Chile are beginning to sense the need for an organization to deal with such funding.

Dr. Villalobos has commented on the need for such an entity.[71]

The first known Chilean AIDS cases involved homosexuals. It is suspected that each patient had been exposed to HIV infection during trips to the USA. The initial AIDS cases in the two countries involved persons of relatively high income levels who evidently were homosexuals and who had travelled to the U.S. East Coast. It also is suspected that the HIV-infected persons, upon return to their home countries, spread the virus to their sexual partners, introducing the initial wave of cases.

In the USA, it was reported the first known cases were among homosexuals, Haitian emigres and victims in the African continent. The mass media erroneously contributed to the stereotype of AIDS being the problem of only certain types of people.

Those stereotypes were repeated as mass media in Latin America disseminated the foreign news. For example, Manuel Prenafeta[72] of El Mercurio, Santiago de Chile, said that most of the initial news there about AIDS was sensationalist and impugned the victims rather than focusing on the public health problem--more or less perpetuating the biased belief that it was "God's punishment" against AIDS victims who were members of groups that were socially ostracized due to deviant behavior.[73]

Prostitution is legal in Chile. That means the estimated 10,000 female prostitutes are likely to be reached or served by STD programs. However, there are an estimated 5,000 male prostitutes.[74]

The cost of an AIDS test in Chile is high, relative to per capita income: It can range from $US 60 to $US200. The cost factor may constitute a problem as persons who fear they have AIDS give blood at public health institutes in hopes that the blood screening will provide them with results free.

In 1984, the Chilean government required official notification concerning AIDS carriers detected by medical personnel, health services and laboratories.

The Ministry of Health operates an official AIDS hotline. Early traffic was 300 calls a day.[75] In July 1988 a national program of TV spot advertisements on AIDS was scheduled to begin. By the end of January 1989, there were to be three TV spot ads--for pregnant women, for families and for sexual partners.[76]

Dra. Blanca Campos, director of the AIDS program at the health ministry, organized three conferences concerning AIDS epidemiology and health communication during 1988, with the aid of the second author of this paper.

Another health event that contributed to public consciousness of efforts against AIDS was the major conference held in Chile concerning the disease, On March 23-26, 1988, as

part of the Jornadas Clinicas and Jornadas de Enfermeria. Unlike the Quito conference, mentioned earlier, the Chilean conference included mass communication professionals as participants in a round-table entitled, "Comunicadores Sociales y SIDA" (Social Communicators and AIDS).

Chile also has mounted an ambitious AIDS education program through its schools. An early effort was a cartoon-illustrated booklet, "SIDA...Un Problema de Todos...Su Obligación Es Estar Bien Informado (AIDS...Everyone's Problem...Your Obligation Is to Be Well Informed)." Some 750,000 copies of that brochure were directed to the nation's schools.

Chile also has developed a curriculum plan that integrates discussion about AIDS in various courses at different grade levels, rather than addressing the problem in one course. A similar approach has been used in Sweden in regard to sex education in the schools.[77]

The private sector also has become involved in supplementing government efforts, as in the USA. By early 1988, Chilean newspapers had published more than 500 articles about AIDS.

Some mass media efforts have been ambitious. For example, in May 1986, the daily La Tercera developed a series of educational booklets, with the cooperation of Dr. Villalobos, according to Lucía Zamora[78]. There was evident concern about public objections, so the material was specially prepared in

sealed packages for Sunday distribution. The favorable response was what was unforeseen: The newspaper sales on Sundays when the booklets were distributed increased 50 percent due to the booklet.

The Chilean media also have publicized efforts of homosexual organizations to organize in order to combat AIDS,[79] a turn-around from scapegoating that occurred earlier.

Additionally, a private organization, Asociación Chilena de Protección de la Familia (APROFA) has been active in creating and diffusing information about AIDS and preventive measures. The Instituto Nacional de Capacitación Profesional (INACAP) has collaborated in the project.

COLOMBIA: The Ministry of Health announced a plan to undertake a national program to study and combat AIDS and to educate the public.[80] The announcement was made during a national seminar in which the president of the National Medicine Academy, Pablo Gomez Martínez, said that in August 1987 Colombia probably had 10,000 to 20,000 residents infected with the AIDS virus, in addition to 200 with full-blown AIDS.[81] As Table 1 shows, the figure had risen to 308 by the end of January 1989. The estimation of HIV carriers was 100-200 times greater than the total the Ministry of Health had announced.[82]

HAITI: TV programs are utilized to teach heterosexuals and homosexuals how to avoid AIDS.[83]

MEXICO: Mexican health authorities have treated AIDS as a priority health concern since 1986. The following year, the government organized the Consejo Nacional de SIDA (National Council for AIDS), known as CONASIDA. The office is run by the Epidemiological Center of the Ministry of Health, and includes representatives of all four major Mexican public health institutions: El Instituto Mexicano del Seguro Social (IMSS), the Instituto de Salubridad y Seguro Social de los Trabajadores del ESTADO (ISSSTE), the Dirección para la Integración Familiar (DIF) and the Secretaria de Salud (SSA).

The objectives of CONASIDA are to (1) keep epidemiological records on AIDS, (2) direct all educational efforts in México regarding AIDS-prevention and (3) provide information to the public through the mass media.

A TV education campaign was commenced by the government during Spring 1987. It was organized to clarify the ways AIDS is spread and to educate the public regarding safer sex practices, including advocacy of use of condoms. A second stage involved distribution of matchboxes each containing a condom and carrying the slogan in Spanish "I do not play with fire."[84] The Catholic Church condemned the campaign as "immoral," saying it promotes homosexuality and prostitution.[85]

Perhaps because of opposition from the Catholic Church and some other small but powerul religious-oriented groups, TV spots have been "softened" to deal mainly with reduction of

people's fear of those with AIDS. Some radio talk shows have begun to deal with AIDS, and newspapers carry stories about the epidemic regularly--often general stories or ones about prostitutes with AIDS. Still, there is a prevailing perception in Mexico that AIDS is mostly a U.S. problem. Health officials are concerned that tourism and prostitution may be principal factors in the spread of AIDS in México, which receives about six million tourists each year from the U.S. and Canada alone. Disposable needles are readily available, reducing the likelihood of spread through contaminated injection equipment. Moreover, officials hold that illicit drug use is less of a problem in México than in the United States and Europe. Also, it is believed that homosexuality involves a relatively small segment of the Mexican population.

Expansion of activities against AIDS was stalled in late 1988 as a result of national elections, the selection of a new President and a wait-and-see attitude concerning the new government's plans.

NICARAGUA: The Sandinista government employs full-page newspaper advertisements to teach "safe sex" procedures, and calls AIDS a disease of "Yankee imperialism."[86]

VENEZUELA: By January 1988, Venezuela had identified 140 AIDS cases, of whom 71 percent had died.[87] Of those cases, 134 were male and 6 female. Comprising the total were 48 homosexuals, 35 bisexuals, 14 heterosexuals, 2 infants, 1 IV

drug abuser and 7 who were infected by transfusions. The first AIDS case in Venezuela was diagnosed in 1983. About a year later, Venezuela's Health Executive of the Ministry of Health and Social Assistance, through its Division of Sexually Transmitted Diseases, published a monograph summarizing research and data on AIDS assembled by an interdisciplinary group of specialists convoked under the National Commission for the Study of AIDS. That commission was formed by official decree on Oct. 8, 1984.

As Table 1 shows, by late January 1989, Venezuela had reported 263 AIDS cases.

Like some other Latin American countries, Venezuela has a long-established STD program. The government's Health Executive, under the Ministry of Health, has a Sexually Transmitted Diseases Division. Its Department of Venereology coordinates a National Institute of Venereology that has 167 venereal disease clinics in 23 political divisions (like states) within the country. That general structure is responsible for planning, programming, supervision, evaluation and technical assistance for some 500 anti-venereal disease centers throughout the nation. Those units are categorized by levels--A, B or C--according to the resources available or the services they can provide. The organizational network was created initially to combat the spread of diseases like syphilis and gonorrhea.

Since the early 1970s, centralized data collection on epidemiological patterns has been instrumental in the study, analysis and evaluation of STDs in the country.

As in Chile, information was circulated that the first AIDS cases in the country resulted from homosexuals who presumably were infected during trips to the United States. News reportage erroneously suggested that AIDS was not a problem threatening the Venezuelan masses. Eduardo Delpretti[88] of El Nacional in Caracas, Venezuela, said the label of "gay cancer" was soon given to the AIDS epidemic in his country.

Since prostitution is legal in Venezuela, it is easier to follow up on health contacts. Moreover, Venezuelan health officials contend there are very few known homosexual prostitutes, though the authors of this paper have heard otherwise in regard to Caracas, at least.

Tourism continues to be of great concern to the Venezuelan epidemiologists, since the country hosts some 800,000 tourists a year.[89] An average of 1,550 tourists arrives daily by air transport alone--mostly from the U.S. Posters have been put up in restaurants and other places giving "do" and "do not" advice about AIDS, including one that advises against intercourse "con personas gay o bisexuales de los Estados Unidos" ("with gay or bisexual persons from the U.S.")

In 1985, the Health Executive, through the STD Division, published a monograph including research and data concerning

AIDS, acting under an official decree (33.079, dated October 8, 1984). The content was compiled by an interdisciplinary group of experts constituting the National Commission for the Study of SIDA.

As in Chile, there is discussion in Venezuela of the need to establish an organization to deal with funding of AIDS work. Dr. Solano sees a further need a national foundation that could help deal with AIDS by facilitating mobilization of all public, private, governmental and other institutions' financial efforts, under the Health Executive of the Ministry of Health and Social Assistance.[90]

One of the early efforts of the Division of Sexually Transmitted Diseases of the Ministry of Health involved distribution of a mimeographed brochure that parallels the one prepared by U.S. Surgeon General Koop on AIDS and what is now called "safer sex."

More recently, the Venezuelan mass media of communication have provided a public platform for health experts to present their opinions and predictions about AIDS. Data concerning AIDS in Venezuela tends to be presented in a world context--which could be invaluable in helping audiences keep the disease's threat in perspective.

An education campaign in the schools was instituted in 1987.

A CLOSE-UP: THE AIDS PROBLEM IN BRAZIL

Considering that Brazil is the largest country in Latin America--it is physically larger than the 48 contiguous states in the USA--and has the largest AIDS case-load in Latin America, it is instructive to consider that country's problems in greater detail.

As stated earlier, the Ministry of Health's October 1987 report put the number of Brazilian AIDS cases at 2,000.[91] By January 1989, the total was 4,709 cases (refer to Table 1). The Ministry can only guess at the number of persons infected with HIV: 300,000 is an estimate.[92] It was expected that by 1991, Brazil would have about 1 million AIDS virus-carriers and perhaps 80,000 with full-blown AIDS.[93] Even with the U.S. experience about AIDS cases doubling every 11 months, the estimate of 80,000 cases seems pessimistic, unless under-reporting is rampant.

The epidemiological pattern of AIDS' spread in Brazil is not overly clear, suggesting a need for strengthening of research and data reporting. However, it is believed homosexuals account for about 56 percent of the AIDS cases.[94] Blood transfusions reportedly accounted for another 14 percent of the AIDS cases--as compared to 7 percent in France, 2.3 percent in the USA, 2 percent in West Germany and 2 percent in England.[95] It is likely that prostitutes constitute another HIV-infected group. A study released by the U.S. Centers for

Disease Control in March 1987 about presence of the virus in the USA might provide an approximation: 11 percent of the prostitutes tested had the virus.[96]

Brazilian firms began marketing AIDS test kits in December 1986, according to Veja.[97] The cost per test was about 500 cruzados.[98] By October 1987, the cost per test had risen to 900 cruzados, reflecting Brazil's monetary inflation problems.[99]

However, virtually at the end of 1986, the Ministry of Health had not even ordered production of an AIDS education poster ("jamais mandou confeccionar um cartaz," as Veja expressed it).[100] It was announced that a budget for a national AIDS campaign would be considered in mid-January of 1987.[101]

About the first of the year, mass media coverage concerning the AIDS issues increased considerably. Polls, documentaries, editorials and posters about AIDS began to appear throughout the country.

As stated earlier, the government approved an AIDS campaign budget equivalent to approximately US$ 2 million--only to cut it in February 1987 to about US$ 600,000.[102] That represented an 89 percent reduction. Of the justifications cited (above) by Dr. Chequer of the AIDS task force, there is validity to the concerns about costs.

Brazil has the largest foreign debt in the Third World and is stretched financially to provide medical services for the nation of 138 million people.[103]

The annual cost of AIDS medical care in Brazil is expected to reach $US 75 million by 1991, according to the coordinator of the country's AIDS task force.[104] "Given our economic situation, this is something we can't handle," the doctor said.[105]

Paulo César Bonfim a medical technician who is president of the Support Group for the Prevention of AIDS in São Paulo commented that there are only about 200 hospital beds available in all Brazil for AIDS patients, as contrasted with the 1,000 that are needed.[106] The Brazilian Ministry of Health estimates there are 8 million persons in the country who are affected by sexually transmitted diseases (STDs), with 60-70 percent of those cases involving syphilis and gonorrhea.[107] Moreover, large numbers of Brazilians in less developed areas of the immense country require treatment for leprosy, sleeping sickness and schistosomiasis, which is a chronic parasitic infection that can destroy kidneys, liver or other organs.[108] Brazil also has problems with malaria and Chagas disease, which is spread by beetles and causes serious illness and heart damage.

Although in 1987 the Ministry of Health mandated the testing of transfusion blood supplies for the AIDS virus,[109] Veja had reported in December 1986 that the rate of testing

ranged from 20 percent in some states to 100 percent in some urban areas including the Federal District.[110] That report indicated that blood not screened for AIDS was most often used in private medical institutions in poorer areas.[111] In Brazil, private laboratories supply the needed blood.[112] Autologous blood transfusion (i.e., banking of one's own blood for use in transfusions), reportedly was increasing.[113] The cost of testing constitutes a serious budgetary problem--not only for Brazil but for other countries, as well.

AIDS victims' hopes for access to the life-prolonging drug AZT are largely dashed by economic reality in Brazil: The cost of a week's supply of AZT was roughly equivalent to US$ 1,800 in March 1987.[114] Although there reportedly was a possibility that AZT might be produced eventually in Brazil, the firm that developed the drug was said to be able to produce supplies only adequate to treat 10 million persons worldwide.[115]

The size of the Ministry of Health's AIDS task force also has reflected budgetary constraints. The Ministry of Health's "Programa Nacional de Contrôle e Prevenção de AIDS" (National Program for Control and Prevention of AIDS) at mid-year 1987 had a staff of five doctors and one secretary.[116] The AIDS task force's campaign has been supplemented by other government agencies. The brochure issued during Carnival was monitored by physician José Padilha de Castro of the Divisão Nacional de Vigilencia Sanitária de Portos, Aeropuertos e Fronteiras.[117]

The government printed 500,000 warning fliers in four languages for an estimated 400,000 international visitors to Carnival.[118] Additionally, there is the information campaign initiated by the Minister of the Army (mentioned earlier).

Other than messages in the Brazilian media effort that were cited earlier, themes urge increased use of condoms to limit the spread of AIDS through homosexual activity, prostitution and other intercourse outside of marriage.[119]

While it is true that condoms are marketed openly in urban areas in Brazil, it is a radical departure from tradition to see them advertised--and especially to women, but that is happening. One slogan advises women that "preservativos" (another euphemism for condom) are "Seguro e inteligente" (Safe and intelligent).[120]

On the optimistic side, the coordinator of the Brazilian AIDS task force has said there are informal or anecdotal indications that married males are reducing sexual affairs with women outside of their marriages.[121] Also, the official said, there is anecdotal evidence of a reduction in sexual contacts between homosexual men and increased use of condoms during their sexual engagements.[122]

An opinion poll published early in 1987 by the newspaper Folha de São Paulo disclosed that more than 50 percent of urban residents were concerned about catching AIDS, and 20 percent said they had changed their sexual habits. Moreover,

57 percent of those who identified themselves as homosexuals in the poll said they had reduced their numbers of partners.

Ironically, there are other changes in Brazilian sexual behavior that might pose problems in the war against AIDS--namely, advances in birth-control practices that have been promoted in that nation. Women who use the pill to control conception or who have been sterilized surgically and are sexually active could be at risk of the disease because they believe condoms are no longer important in their lives. A poll by the prestigious Instituto Brasileiro de Geografía e Estatística found 27 percent of the women who were married or living together had undergone surgical sterilization; another 15 percent were found to rely on birth control pills for contraception.[123]

It also is not clear what the epidemiological trends are concerning women who become pregnant while knowingly or unknowingly HIV-infected, passing the AIDS virus on to their offspring. The problem is one of great magnitude, especially among poorer persons: For example, in Boston's and New York's inner-cities, preliminary findings suggest that as many as 1 newborn in 60 is infected.[124] Clearly, AIDS campaign planners need to consider the priority they assign to messages directed to women, particularly in poorer areas, who are likely to become pregant and abuse drugs or live with males who engage in AIDS high-risk epidemiological behaviors.

The AIDS epidemic also threatens to erode the progress of Brazil's "gay-liberation" movement, suggesting a need for communications about AIDS that are designed to reduce social tension and prejudice.

Rio and São Paulo are relatively tolerant toward "gays." However, there is anecdotal evidence that tension in the non-gay population might be on the rise. A news report from Rio indicated that a crowd of 100 persons watched as three gunmen cornered and killed a person they suspected as being a rapist with AIDS. The report said the killers left a sign on the body. As translated, it said: "I no longer spread AIDS."[125]

Moreover, Brazilian AIDS patients or their families reportedly request that doctors classify the illness as something other than Acquired Immunodeficiency Syndrome.[126] Consequently, publicity about the homosexual connection may be suppressing the true percentage of reporting of bisexual or homosexual AIDS cases.

CONCLUSION

The AIDS epidemic is growing in Latin America and the Caribbean. Brazil, Haiti and México--in that order--have the largest numbers of cases in the Americas, exceeded by far by the USA.

The reporting of statistics on the over-all prevalence, increase rate, and demographic categories that are most

afflicted by the AIDS virus in Latin America is unsatisfactory, as Dr. Mann of WHO has noted.[127] Those data are essential not only for epidemiological tracking, but also as the basis for audience segmentation strategy formulation in health information/education campaigns.

Political and moral debates continue to rage over the acceptability of widespread or mandatory testing that presumably would be needed to obtain the best quality representative data; the other side of the issue is concern for privacy and what forces might be directed against persons identified as being HIV-infected or afflicted with full-blown AIDS. Interestingly, however, México has tested the blood of persons in a household sample that reached 70,000 of that nation's 80 million citizens.[128] Beyond the political and moral issues, there are huge problems regarding the costs and infrastructure required to collect, process, analyze and report epidemiological data quickly.

The comment from PAHO's Dr. St. John about the problem of trying to change sexual behavior in Latin America when so little is known about such behaviors gets to the heart of the education and behavior-change problems. Information and education campaigns are likely to be less efficient when they are not based upon health beliefs and behaviors in target audience segments. Providing information about health risks is one thing; getting people in high-risk groups to change

their behaviors is much more complicated.[129] While campaign activity designed to create general public awareness of AIDS is appropriate, globally the lack of understanding of decisionmaking factors in specific high-risk groups can--as PAHO's Dr. Bond noted--mask critical factors that explain resistance to salutory changes in behaviors. Simmons, Hills and Lee have discussed belief systems as rule structures that might help explain adoption and nonadoption of advocated preventive health measures.[130]

Anecdotal reports of changes in sexual behavior in the face of the AIDS epidemic are problematic. A case in point is the inexplicable rise in other sexually transmitted diseases (STDs) in the U.S. at a time when extensive public health education campaigns in the AIDS epidemic advise about the risks of not using "safer sex" or abstaining altogether.

In regard to the initiation of mass communication efforts designed to inform publics about AIDS, evidence in this paper suggests that in Latin America, as in the USA, the epidemic has been allowed to run ahead of discussion in mass media that might have helped prevent new cases of infection. Furthermore, although Dr. Mann of WHO is justified in lauding Brazil's AIDS mass education campaign--especially vis-à-vis the extent of public health education that is occurring (or not occurring yet) in other Latin American or Caribbean nations--even Brazil's program has suffered problems of the scale of

activity due to here-today-gone-tomorrow political and financial support.

There also is a need for research on health information diffusion networks in Latin America. There is a real potential for using "multiple-step flow" concepts--i.e., learning how content is retransmitted in a human information network after it has been received from mass media or interpersonal sources. For example, campaign strategy might consider how the information transmitted via satellite from the Quito and Rio teleconferences might have been efficiently rediffused by the health specialists in the teleconference audience to specific segments in the population. There also is a need for investigation of the comprehension of information about AIDS that resulted among health workers who participated in the teleconferences; evaluation to date has stressed number of participants, locations and opinions about the value of the teleconferences.

Although some health officials such as U.S. Surgeon General Koop and WHO's Dr. Mann have become virtual mass media personalities as spokespersons in the war on AIDS, too many health experts see AIDS as a "health matter" and do not think in terms of the potential offered by collaboration with mass media, community education, public relations or advertising and health communication specialists. Yet, those specialists can work with health experts to plan, create, deliver and evaluate

health campaigns intended to improve the public welfare.

Moreover, the Quito conference on AIDS in Latin America evidently was conceptualized as a "health event" although it also could have been exploited as a "media event" that would have diffused information through the mass media to publics throughout Latin America. (As an example, although TV and other media in Brazil gave some coverage, the major Brazilian news magazine Veja, which has published a substantial number of articles about AIDS since mid-1986, did not have coverage of the Quito conference.)

If the issue of how to improve the retransmission of preventive health maintenance information that is available to health specialists is not addressed, much of that information will not become available to Latin American audience segments that need it urgently.

Criticism from the USA does not imply that the "Colossus of the North" fares a great deal better in regard to the federal government's AIDS education program. Luckily, however, in a wealthier economy those deficiencies have tend to be offset in large degree by efforts contributed by public volunteer organizations (PVOs), church groups, city and state agencies, mass media and communications organizations such as the Ad Council, which provides help in getting advertisements prepared for nonprofit use. Chile also is making good use of PVOs and mass media cooperation.

Moreover, in the USA there is the availability of public service announcements (PSAs)--that is, the mass media carry messages free for worthy nonprofit causes. Two cases in point: The majority of AIDS education messages in the USA are carried by the mass media as PSAs, and the U.S. federal government's official campaign is predicated in large part on use of PSAs.

In regard to assistance with campaigns, the World Health Organization has given active support to AIDS-related activities in different countries, especially in Africa and Latin America, where the epidemic's threat is pronounced. The problem, though, is that, as WHO's head Dr. Halfdan Mahler says, WHO might require a budget of $1.5 billion a year by 1990 to provide support for its international campaign efforts.[131] The USA, Britain, Sweden, Norway, Finland and the Netherlands are among nations that contributed a total of more than US$ 7 million to get the WHO campaign under way.[132]

Beyond that effort, the U.S. Agency for International Development is financing two projects to help LDNs combat the AIDS epidemic: AIDSTECH and AIDSCOM. The first is designed to provide epidemiological and medical expertise. The latter is designed to provide communication analysis, planning, theory, message-creation and message-distribution and evaluation research support.[133]

The AIDSCOM project is predicated on the belief there is a need for a behavioral-managerial approach to the planning and

supervision of AIDS campaigns, due to the necessity to gain maximum impact on education and behavior-change at the lowest possible cost.

Simmons and Mujica[134] have suggested minimal criteria for management of massive health education campaigns[135] in the AIDS epidemic:

- Exploratory research to ground the campaign--for example, to identify critically important audience segments and help determine strategies and set priorities.
- Application of audience segmentation techniques--drawing upon techniques used in marketing, advertising and public relations to improve efficient targeting of a campaign, especially in view of limited resources. As an analogy: One cannot extinguish a fire efficiently by wasting too much water in the wrong places.
- Identification of information, beliefs and situational factors that control the particular health behavior--which should lead to conceptualization of the problem within the context of existing health behavior models or other behavioral models; those models emphasize that different groups do not tend to respond uniformly or effectively to all-purpose messages, because the groups' beliefs and motivational agendas vary.
- Use of behavioral objectives or Management by Objectives (MBO) in planning--which is essential to ensure that the messages that should be produced actually are produced, and also to facilitate the evaluation of the effectiveness of the impact of the individual messages and that of the entire campaign.
- Design of a message-delivery plan--with such a plan utilizing a mix of channels (both mass media and human) to optimize the likelihood of both exposure in the designated audience segments and social influence that would enhance the possibility of change. The message-delivery plan also must ensure sufficient repetition over time to (a) facilitate learning and (b) keep the campaign messages from "disappearing from view" in the intended audience over time.

The human and other costs of not communicating effectively about AIDS in the face of the worldwide epidemic--especially when expert knowledge about health behavior, communication and management is readily available--should be unacceptable to society.

END NOTES

1. Pan American Health Organization, Evaluation Report: The First Pan American Teleconference on AIDS (Washington: Pan American Health Organization, 1988).

2. Correspondence from Dr. Lydia Bond, director, AIDS Health Promotion and Counseling, Health Situation and Trend Assessment Program, Pan American Health Organization, Washington, 28 October 88.

3. Washington Post, 15 September 87, p. HE7.

4. Ibid.

5. Phone conversation with Pan American Health Organization, 7 February 89.

6. Conversation with U.S. Centers for Disease Control, Atlanta, 7 February 89.

7. Conversation with the Pan American Health Organization, 7 February 89.

8. Veja, 7 October 87, pp. 68-74.

9. Conversation with the Pan American Health Organization, 7 February 89.

10. Ibid.

11. Washington Post, 15 September 87, p. HE7.

12. Washington Post, 22 September 87, p. HE9.

13. U.S. News & World Report, 12 January 87, p. 60.

14. Christian Science Monitor, 1 May 87, p. 8.

15. Washington Post, 25 August 87, p. HE6.

16. National Public Radio news, 30 January 88.

17. Boston Globe, 30 March 87, p. 3.

18. Christian Science Monitor, 1 May 87, p. 8.

19. U.S. News & World Report, 12 January 87, p. 61.

20. Boston Globe, 26 March 87, p. 4.

21. Boston Globe, 21 March 87, p. 1.

22. Christian Science Monitor, 1 May 87, p. 8.

23. Washington Post, 22 September 87, p. HE9.

24. Boston Globe, 28 January 88, p. 22.

25. ADWEEK [Southeast Edition] (Nexis), 5 October 87.

26. Ibid.

27. Boston Globe, 8 January 87, p. 2.

28. Washington Post, 22 February 1987, p. A27.

29. Associated Press (Nexis), 6 June 87.

30. World Press Review, February 1987, p. 8.

31. Ibid., pp. 8-9.

32. Robert E. Simmons and Gladys Mujica, "Efficiency of Educational Efforts Concerning AIDS Hurt by Lack of Managerial and Behavioral Structure," Markeur, marketing journal of Erasmus University, Rotterdam, September 1987. [UNICEF asked and received permission to distribute the manuscript to its offices abroad.]

33. Ibid.

34. Washington Post, 13 August 87, p. A13.

35. Washington Post, 20 June 87, p. A14.

36. Ibid.

37. Christian Science Monitor, 14 January 87, p. 12.

38. Washington Post, 15 September 87, p. HE7.

39. Ibid.

40. Ibid.

41. Ibid, p. 9.

42. Pan American Health Organization, "Evaluation Report...," p. 2.

43. Washington Post, 22 September 87, p. HE9.

44. Simmons and Mujica, op. cit. Also consult Stella R. Quah, "The Health Belief Model and Preventive Health Behaviour in Singapore," Social Science and Medicine, 1985, 21(3): pp. 351-63.

45. Robert E. Simmons, "Measurement of Motivational Rewards in Smoking: Assessing Valenced Outcomes that Also Differentiate Audience Segments," presented to the Health Communication Division, International Communication Assn., Montreal, May 1987.

46. Interview with Dra. Astarloa, Viña del Mar, Chile, 22-26 March 1988.

47. Página, 1 July 1987, p. 9.

48. Ibid.

49. Associated Press (Nexis), 6 June 87.

50. Foreign Broadcast Information Service, 10 July 87, S2.

51. Expreso, 19 June 87, p. 54.

52. Ibid., p. 58.

53. Ibid., p. 58.

54. Ibid., p. 56.

55. Los Angeles Times (Nexis), 9 August 87.

56. Veja, 18 February 87, p. 83. As explained earlier, Brazil has preferred to use the international identifier "AIDS"

rather than "SIDA" (Sindrome de Inmunodeficiencia Adquirada) used in the Spanish-speaking countries.

57. Ibid.

58. Ibid.

59. Ibid.

60. Boston Globe, 1 February 88, p. 3.

61. Veja, 9 September 87, p. 91.

62. Ibid.

63. Newsweek, 27 July 87, p. 38.

64. Veja, 28 January 87, pp. 64-66.

65. Los Angeles Times (Nexis), 9 August 87.

66. Veja, 17 December 86, pp. 76-78.

67. Veja, 7 October 87, pp. 68-74.

68. Interview with Dr. Villalobos at conference on AIDS, Viña del Mar, Chile, 23-26 March 1988.

69. Ibid.

70. Ibid.

71. Ibid.

72. Conference on AIDS, Viña del Mar, Chile, March 1988.

73. Interview with Delpretti, Caracas, January 1988.

74. Interview with Dr. Villalobos, 23-26 March 1988, Viña del Mar, Chile.

75. Associated Press (Nexis), 6 June 87.

76. Interview with Dra. Blanca Campos, director of the AIDS program of the Ministry of Health, Santiago de Chile, 7 November 87.

77. Interview with Maria Paalman, director, Dutch Foundation for STD Control (Nederlandse Stichting tot

Bestrijding van Sexueel Overdraagbare Aandoeningen), Amsterdam, 27 October 1988.

78. Interview with Lucía Zamora, Viña del Mar, Chile, 25 March 1988.

79. An example: Apsi, 25 April, 1988.

80. Boston Globe, 24 August 87, p. 23.

81. Ibid.

82. Ibid.

83. Ibid.

84. Los Angeles Times (Nexis), 9 August 87.

85. Ibid.

86. Ibid.

87. Interview with Dr. Solano, 5 May 1988, Caracas.

88. Interview with Delpretti, Caracas, January 1988.

89. Interview with Dr. Solano, 5 May 1988, Caracas.

90. Ibid.

91. Veja, 7 October 87, pp. 68-74.

92. Newsweek, 27 July 87, p. 38.

93. Ibid.

94. Veja, 17 December 86, pp. 76-78.

95. Veja, 7 October 87, pp. 68-74. Screening of blood probably will reduce these percentages eventually. In the USA, since screening has been initiated, as few as 70 to 365 AIDS cases per year are expected to result from transfusions where the tests have failed to detect the virus in blood or blood products.

96. Boston Globe, 27 March 87.

97. Ibid.

98. Veja, 10 October 86.

99. Veja, 7 October 87, pp. 68-74.
100. Ibid., p. 77.
101. Ibid.
102. Veja, 18 February 87, p. 83.
103. Newsweek, 17 July 87, p. 38.
104. Boston Globe, 8 June 87, p. 41.
105. Ibid.
106. Los Angeles Times (Nexis), 9 August 87.
107. Veja, 28 January 87, pp. 64-66.
108. Ibid.
109. Ibid.
110. Veja, 7 October 87, p. 69.
111. Veja, 17 December 86, pp. 76-78.
112. Washington Post, 15 September 87, p. HE7.
113. Ibid.
114. Visão, 25 March 87, pp. 48-49.
115. Ibid, p. 49.
116. Newsweek, 27 July 87, p. 38.
117. Veja, 18 February 87, p. 83.
118. Newsweek, 27 July 87, p. 38.
119. Christian Science Monitor, 1 May 87, p. 8.
120. Veja, 28 January 87, pp. 64-66.
121. Christian Science Monitor, 1 May 87, p. 8.
122. Ibid.
123. Veja, 11 November 87, p. 79.
124. Boston Globe, 2 February 88, p. 1.

125. Star-Tribune (Minneapolis), 17 January 88, p. 1E.

126. Los Angeles Times (Nexis), 9 August 87.

127. Washington Post, 25 August 87, pp. HE6-7.

128. Washington Post, 15 September 87, p. HE7.

129. Katie Leishman made a similar point in her extensive investigative report, "Heterosexuals and AIDS," Atlantic, February 1987, pp. 39-58. The article is especially recommended by the authors of this paper.

130. Robert E. Simmons, Carol L. Hills and Jung-Sook Lee, "Behavioral and Managerial Models That Can Help Improve AIDS Campaign Planning," presented before the Health Communication Division, International Communication Assn., New Orleans, May 1988.

131. Christian Science Monitor, 14 January 87, p. 12.

132. Ibid.

133. Information about AIDSCOM may be obtained by contacting the following agencies: AIDSCOM Project, Academy for Educational Development, 1255 23rd St. NW, Washington, DC 20037 or AIDSCOM Project, Office of Education, Bureau for Science and Technology, U.S. Agency for International Development, Washington, DC 20523. AED is the prime contractor for the project.

134. Simmons and Mujica, op. cit.

135. Another perspective on educational campaigns for developing countries that is based in the behavioral and managerial traditions can be found in Alan Hancock's Communication Planning for Development: An Operational Framework (Paris: UNESCO, 1981).